

HRA Form

Health Plan :	Optima Health
Member Name :	KIMBERLY M HENRY
Evaluator Name :	Jacqueline Brown, NP
Assessment Type :	Health Risk Assessment
DOB :	1961-01-17
Evaluation Date :	2021-6-5 12:00 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	OHP - OPTIMA
Program	MEDICARE
LOB	DSNP
Name	KIMBERLY M HENRY
Gender	Female
Address	1417 WENTWORTH DRIVE UNIT 101
City	VIRGINIA BEACH
State	VA
Zip	23453
Date of Birth	1961-01-17
Age(as of date)	61
Marital Status	Single
Member Identification Number	900039032*01
HICN	
Phone Number	865/307-5144
Cell Number	865/307-5144
Alternate Contact Number	865/307-5144,
Email	
Emergency Contact	Nakeeya Craig - Daughter
Phone Number	757-450-1821
Primary Care Physician	DONALDSON, NICOLE MD
Phone Number	757/227-6866
PCP Address	SUITE 504 301 RIVERVIEW AVENUE
PCP City	NORFOLK
PCP State	VA

PCP Zip	23510
PCP County	
Office ID	161071
Office Name	Fort Norfolk Plaza Primary Care

1. Race

- ☐ Caucasian
 ☒ **African American**
☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☐ Other

Patient's Ethnicity

- ☐ Hispanic
 ☒ **Non-Hispanic**
☐ Other Ethnicity
- ☐ Prefer not to say

2. Preferred language

- ☒ **English**
☐ Other

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Had close contact with someone who has traveled to a high risk area?	Yes	No
Developed Fever?	Yes	No
Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

Self-Assessment and Social History

3. How much school have you completed?

- ☐ Less than 3rd grade
 ☐ Completed 3rd grade
 ☐ Completed 8th grade
- ☒ **Completed 12th grade**
☐ Attended College

4. When you get written information at a doctor's office would you say it is

- ☐ Very difficult
 ☒ **Somewhat difficult**
☐ Easy
- ☐ Very easy to understand

comments

5. When you read the instructions on a prescription bottle would you say that it is

- ☐ Very difficult
 ☒ **Somewhat difficult**
☐ Easy
- ☐ Very easy to understand

comments

6. How confident are you in filling out medical forms by yourself?

- ☐ Not at All Confident
 ☒ **Not Very Confident**
☐ Confident
- ☐ Very Confident

comments

7. How would you rate your health compared to other persons your age?

- ☐ Excellent
 ☒ **Good**
☐ Fair
- ☐ Poor

8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?

- ☐ Often
 ☒ **Sometimes**
☐ Almost Never
- ☐ Never

9. Where do you currently live?

- ☒ **Home**
☐ Apartment
 ☐ Assisted Living
- ☐ Nursing Home
 ☐ Homeless
 ☐ Other

10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?

- ☒ **Yes**
☐ No

11. Who do you currently live with?

- ☐ Alone
 ☐ Spouse
 ☐ Partner
- ☐ Relative
 ☒ **Family**
☐ Friend
- ☐ Personal Care Worker

comments

12. Are you currently a caregiver for someone?

- ☐ Yes
 ☒ **No**

13. Tobacco use

- ☐ Current
 ☒ **Former**
☐ Never
- ☐ Type
 ☒ **Cigarettes**
☐ Cigars
 ☐ Chewing Tobacco
- ☐ Vaping
 ☐ Other
- ☐ How Many

☐ 1 - 3 a day
 ☒ 1/2 a pack
 ☐ 1 pack
☐ More than 1 pack
 ☐ Other

comments

quit 3 years ago, 1/2ppd x45 years

14. Alcohol Use

☐ Current
 ☒ Former
 ☐ Never

comments

quit 15 years ago

How many drinks	How Often
Select	Select

15. Do you or have you used recreational drugs or pain medication?

☒ Yes
 ☐ No

Which drugs or medication

used marijuana, quit 15 years ago and chronic pain - vicodin, fiorcet

16. Do you have a Healthcare Proxy?

☐ Yes
 ☒ No
 ☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes
 ☒ No
 ☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes
 ☒ No
 ☐ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True
 ☐ Sometimes True
 ☒ Never True

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help

How far can you walk

- ☐ Household only
 ☐ Less than one block
 ☐ One block
 ☐ Two or more blocks
 ☒ **Non-ambulatory**

H. Going up or down stairs	No	Need Some Help	Need Total Help
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How many stairs can you climb

- ☒ **None**
☐ Three to five
 ☐ Six to ten
 ☐ More than ten

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

- ☐ None
 ☐ Cane
 ☐ Walker
 ☐ Prosthesis
 ☐ Wheel Chair
 ☒ **Bedside Commode**
☐ Urinal
 ☒ **Bed Pan**
☒ **Other**

21. Are you currently seeing any specialists?

- ☒ **Yes**
☐ No

Medical Specialty	Specialist	For
Other	Rheumatologist	SLE
Cardiologist		CHF
Neurologist		Epilepsy
Pulmonologist		OSA, COPD

22. In the past 12 months how many times have you?

A. Seen your PCP	None	1	2	3	4	5 or more
B. Visited the Emergency Room	None	1	2	3	4	5 or more

If one or more, describe

COVID

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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If one or more, describe

COVID

D. Been in a nursing home	None	1	2	3	4	5 or more
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If one or more, describe

Post COVID

E. Had Surgery	None	1	2	3	4	5 or more
----------------	------	---	---	---	---	-----------

23. Have you ever been hospitalized prior to the last 12 months?

☒ Yes

☐ No

[Describe COVID](#)

24. In the past year have you received health services from any of the providers below:

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No
Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No
Meals on Wheels	Yes	No

25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes

☐ No

Family Member	Medical Condition	Cause of Death
Father		lung cancer
Mother		DM, SLE

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Yes
Cervical Screening	No
Bone Density	Yes
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	No
If Diabetic Foot Exam	No
If Diabetic Hgb A1c screen	No
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

- ☒ 3 – 5 years ago
 ☐ 6 – 10 years ago
 ☐ > 10 years ago
☐ Never
 ☐ Don't know

29. Screen for abnormal glucose / diabetes - age 40 - 70

- ☒ Yes
 ☐ No
 ☐ NA

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

- ☐ Yes
 ☐ No
 ☒ NA

31. One time screen for Hepatitis C if born between 1945 - 1965

- ☒ Yes
 ☐ No
 ☐ NA

32. Do you get Flu Vaccine each year?

- ☒ Yes
 ☐ No

33. Have you been vaccinated for Pneumonia?

- ☒ Yes
 ☐ No
- ☒ Yes
 ☐ No
 ☒ Unknown
- ☒ Yes
 ☐ No
 ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ No

Allergies / Medications

35. Allergies

- ☐ Yes
 ☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
	SUCRALFAT E	TAB 5MG	PO = By Mouth	BID	Dr. Donaldson	Taking	Not Taking

Depression	DULOXETINE	TAB 30MG	PO = By Mouth	BID	Dr. John Dye	Taking	Not Taking
Hypokalemia	POT CL MICRO	TAB 20MEQ ER	PO = By Mouth	QD	Dr. S. Williams	Taking	Not Taking
SLE	Hydroxychloroquine	TAB 200MG	PO = By Mouth	BID	Dr. John Dye	Taking	Not Taking
Hypotension	MIDODRINE	10MG	PO = By Mouth	TID	Dr. John Dye	Taking	Not Taking
COPD	Albuterol	90MCG	Select	PRN	Dr. J. Smith	Taking	Not Taking
Hx PE/DVT	BISOPROLOL FUM	TAB 5MG	PO = By Mouth	BID	Dr. John Dye	Taking	Not Taking
	AMLODIPINE		Select	Select		Taking	Not Taking
	BREO ELLIPTA	TAB 30MG ER	Select	Select		Taking	Not Taking
Hx PE/DVT	ELIQUIS	5MG	PO = By Mouth	BID	Dr. John Dye	Taking	Not Taking
	ISOSORB MONO	TAB 5MG	Select	Select		Taking	Not Taking
	VICODIN	TAB 10-325MG	PO = By Mouth	PRN	Dr. X. Cao	Taking	Not Taking
	FUROSEMIDE	GEL 0.01	Select	Select		Taking	Not Taking
	PREDNISONE	CAP 500MG	Select	Select		Taking	Not Taking
Chronic Pain	BUT/APAP/CAF	50-325-40mg	PO = By Mouth	PRN	Dr. X. Cao	Taking	Not Taking
Chronic Pain	HYDROCODONE/APAP	10-325MG	PO = By Mouth	PRN	Dr. B. Horton	Taking	Not Taking
	DICLOFENAC	TAB 10MG	PO = By Mouth	HS	Dr. X. Cao	Taking	Not Taking
	CEPHALEXIN	TAB 1000MCG	Select	Select		Taking	Not Taking
	CALMOSEPTINE	TAB 12.5MG	Select	Select		Taking	Not Taking
	LINZESS	TAB 25MG	Select	Select		Taking	Not Taking
	PANTOPRAZOLE	TAB 20MG	Select	Select		Taking	Not Taking
	PROMETHAZINE	SOL PREP KIT	Select	Select		Taking	Not Taking
	VITAMIN B-12	PAD 0.05	Select	Select		Taking	Not Taking
	AMITRIPTYLINE	CAP 100MG	Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

37. Chronic Use of

- ☐ None
- ☐ ASA
- ☒ Anticoagulants
- ☐ Steroids
- ☐ Statins
- ☐ Insulin
- ☐ Biphosphonate

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
Comment: Administered by daughter		
2. Do you sometimes not pay enough attention to your medication?	Yes	No
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	Yes	No
4. When you feel better do you sometimes stop taking your medicine?	Yes	No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	Yes	No
6. Do you sometimes forget to refill your prescription on time?	Yes	No

Review of Systems and Diagnoses

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

☒ Yes ☐ No

Diagnoses

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease

☒ Difficulty with vision

- ☐ Hyperopia
- ☐ Myopia
- ☐ Others

Difficulty with vision

Describe

☒ Active ☐ History of ☐ Rule out

comments

Farsighted

Legally Blind

☐ Yes ☒ No

Do you wear glasses or contacts?

☐ Yes ☒ No

Do you have problems seeing at night?

☐ Yes ☒ No

Do you have eye pain?

☐ Yes ☒ No

Do you have problems with tearing?

☐ Yes ☒ No

Do you have a problem with dry eye?

☐ Yes ☒ No

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums,

Other)

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)

☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Acute Pulmonary Embolism | <input type="checkbox"/> Acute Upper Respiratory Infection |
| <input type="checkbox"/> Asthma | <input checked="" type="checkbox"/> Chronic Pulmonary Embolism |
| <input type="checkbox"/> Chronic Respiratory Failure | <input type="checkbox"/> Chronic Sputum Production |
| <input checked="" type="checkbox"/> COPD | <input type="checkbox"/> Cystic Fibrosis |
| <input checked="" type="checkbox"/> Hypoventilation secondary to Obesity | <input type="checkbox"/> Hypoxemia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pulmonary Fibrosis |
| <input type="checkbox"/> Respirator Dependence/
Tracheostomy Status | <input type="checkbox"/> Respiratory Arrest |
| <input type="checkbox"/> Sarcoidosis | <input checked="" type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Other | |

Chronic Pulmonary Embolism

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> History of Pulmonary Embolism	<input type="checkbox"/> Insertion of Vena Cava Filter	<input checked="" type="checkbox"/> Anticoagulation beyond six months
<input type="checkbox"/> Other		

COPD

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> Use of accessory muscles	<input type="checkbox"/> Barrel Chest	<input type="checkbox"/> XR results
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Clubbing	<input type="checkbox"/> Decreased or prolonged breath sounds
<input checked="" type="checkbox"/> Dyspnea on exertion	<input type="checkbox"/> O2 use	<input checked="" type="checkbox"/> Brinchodilator medication

☐ Respirator ☐ Other

Has patient been told they have Chronic Bronchitis

☐ Yes ☒ No

Has patient been told they have Emphysema

☐ Yes ☒ No

Is patient on Bronchodilator

☒ Yes ☐ No

Route is

☒ Inhaled

☐ Nebulizer

☐ Oral

↳ Is patient on Steroids

☐ Yes

☒ No

↳ Does patient have current exacerbation

☐ Yes

☒ No

Hypoventilation secondary to Obesity

↳ Describe

☒ Active

☐ History of

☐ Rule Out

↳ Supported by

☒ Morbid Obesity

☐ Use of O2

☐ CO2 Retention

☐ Other

Sleep Apnea

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ Use of CPAP

☐ Positive sleep studies

☐ History of sleepiness during the day

☐ Heavy snoring / restlessness during sleep

☐ Other

Use of Oxygen

☐ Yes

☒ No

Shortness of breath

☒ Yes

☐ No

Wheezing

☐ Yes

☒ No

Chronic Cough

☐ Yes

☒ No

Patient requires durable medical equipment

☒ Yes

☐ No

comments

CPAP

Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)

☒ Yes

☐ No

↳ Diagnoses

☐ Abnormal Cardiac Rhythm

☐ Aneurysm

☐ Angina

☐ Atrial Fibrillation

☐ Cardio – Respiratory Failure / Shock

☐ Cardiomyopathy

☒ Congestive Heart Failure

☐ Deep Vein Thrombosis

☐ Hyperlipidemia

☐ Hypertension

☐ Ischemic Heart Disease (CAD)

☐ Myocardial Infarction

☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension

☐ Valvular Disease

☒ Other

Congestive Heart Failure

<div>Describe</div> <div><input checked="" type="checkbox"/> Active</div>	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<div>Supported by</div> <div><input type="checkbox"/> Ejection fraction</div> <div><input type="checkbox"/> DOE</div> <div><input checked="" type="checkbox"/> Medications</div>	<input type="checkbox"/> Cardiomegaly <input type="checkbox"/> PND <input type="checkbox"/> Peripheral edema	<input type="checkbox"/> Orthopnea <input type="checkbox"/> S3 <input type="checkbox"/> Other
<div>Describe</div> <div><input checked="" type="checkbox"/> Diastolic</div>	<input type="checkbox"/> Systolic	<input type="checkbox"/> Unknown
<div>Secondary to Hypertension</div> <div><input type="checkbox"/> Yes</div>	<input checked="" type="checkbox"/> No	
<div>Is patient on an ACE or ARB</div> <div><input type="checkbox"/> Yes</div>	<input checked="" type="checkbox"/> No	
<div>Is patient on a Beta Blocker</div> <div><input type="checkbox"/> Yes</div>	<input checked="" type="checkbox"/> No	
Other		
<div>Describe</div> <div><input checked="" type="checkbox"/> Active</div>	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<div>Supported by</div> <div><input type="checkbox"/> History</div> <div><input checked="" type="checkbox"/> Medications</div> <div><input type="checkbox"/> Biopsy</div>	<input type="checkbox"/> Symptoms <input type="checkbox"/> Test results <input type="checkbox"/> DME	<input type="checkbox"/> Physical Findings <input type="checkbox"/> Image studies <input type="checkbox"/> Other
<div>Other</div>		

comments

Hypotension

History of Chest Pain

☐ Yes ☒ No

History of Intermittent Claudication

☐ Yes ☒ No

Implanted Pacemaker

☐ Yes ☒ No

Implanted Defibrillator

☐ Yes ☒ No

Do you have abnormal heart beats?

☐ Yes ☒ No

Does your heart race?

☐ Yes ☒ No

Do you sleep on more then one pillow?

☒ Yes ☐ No

have you ever have fluid in your lungs?

☒ Yes ☐ No

Do your legs or ankles swell up?

☒ Yes ☐ No

Do you follow a special diet?

☒ Yes ☐ No

Do you have headaches?

☐ Yes ☒ No

Do you feel light headed when you stand up?

☐ Yes ☒ No

comments

Non-ambulatory

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

☒ Yes

☐ No

Diagnoses

☐ Bowel Obstruction

☐ Cachexia

☐ Celiac Disease

☐ Cirrhosis

☐ Colon Polyps

☐ Diverticulitis

☐ Gall Bladder Disease

☐ Gastroparesis

☒ GERD

☐ Hepatitis

☐ Inflammatory Bowel Disease

☐ Pancreatitis

☐ Ulcer Disease

☐ Other

GERD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☒ Medications

☐ Other

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes

☒ No

History of Heartburn / Dyspepsia

☒ Yes

☐ No

Describe

☐ Occasionally

☒ Chronic

History of Vomiting or Regurgitation

☐ Yes

☒ No

History of pain after eating

☐ Yes

☒ No

History of Jaundice

☐ Yes

☒ No

Do you follow a special diet?

☐ Yes

☒ No

Do you have frequent abnormal abdominal pain?

☐ Yes

☒ No

Do you have intermittent nausea or vomiting?

☐ Yes

☒ No

Do you have trouble with constipation?

☐ Yes

☒ No

Does diarrhea limit your ability to get out of the room or socially?

☐ Yes

☒ No

Do you see blood in your urine?

☐ Yes

☒ No

Do you have Frequent Stomach Pain

☐ Yes

☒ No

Bowel Movements

- ☒ Normal
- ☐ Abnormal

Abdominal Openings

- ☐ Yes
- ☒ No

Rectal Problems

- ☐ Yes
- ☒ No

Last Bowel Movement

- ☒ Today
- ☐ 1-3 days ago
- ☐ >3 days ago

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Alcohol Dependence

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☐ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☒ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☒ Depression

☒ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☒ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Depression

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Symptoms
- ☐ PHQ 2 / 9
- ☒ Use of antidepressant medication
- ☐ Other

Major

- ☒ Yes
- ☐ NO

Supported by

- ☐ PHQ 9
- ☐ Hospitalization
- ☒ Chronic use of antidepressant medication beyond 6 months

☐ Use of ECT

Fibromyalgia

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☐ Symptoms

☐ Physical findings

☐ History

☒ Medications

☐ Other

Peripheral Neuropathy

☐ Describe

☒ Active

☐ History Of

☐ Rule out

☐ Supported by

☐ Physical findings

☐ EMG / Nerve
Conduction studies

☐ Biopsy

☒ Other

Other

☐ Describe

comments

Medication - Lyrica

☐ Secondary to Diabetes

☐ Yes

☒ No

Seizure Disorder

☐ Describe

☒ Active

☐ History of

☐ Rule out

☐ Supported by

☐ History of recurrent
seizures

☒ Medications

☐ Laboratory testing

☐ Other

Are you nervous, anxious, feel on the edge or often feel stressed?

☐ Yes

☒ No

Do you worry too much about different things?

☒ Yes

☐ No

Do you feel afraid that something bad might happen?

☒ Yes

☐ No

History of headaches

☐ Yes

☒ No

History of auditory hallucinations

☐ Yes

☒ No

History of visual hallucinations

☐ Yes

☒ No

History of psychotic behavior

☐ Yes

☒ No

History of episodes of delirium

☐ Yes

☒ No

Do you follow a special diet?

☐ Yes

☒ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☒ Yes

☐ No

Do you have trouble swallowing your food?

☐ Yes ☒ No

Do you have trouble making people understand you when you speak?

☒ Yes ☐ No

comments

Per patient, 2/2 SLE effecting her brain

Do you trouble understanding what people say to you?

☒ Yes ☐ No

comments

Per patient, 2/2 SLE effecting her brain

Do your hands shake?

☐ Yes ☒ No

Do you have convulsions and seizures?

☒ Yes ☐ No

Do you have trouble with your memory?

☒ Yes ☐ No

Do you have trouble finding words?

☒ Yes ☐ No

Do you have trouble sleeping?

☐ Yes ☒ No

Have you lost your appetite

☐ Yes ☒ No

Do you hear voices or see things that other people do not

☐ Yes ☒ No

Do you have highs and lows

☒ Yes ☐ No

Do you ever feel like someone is out to get you

☐ Yes ☒ No

How often do you go out to meet with family or friends

☐ Often ☐ Sometimes ☒ Never

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes ☐ No

↳ Patient oriented to place

☒ Yes ☐ No

↳ Patient oriented to time

☒ Yes ☐ No

↳ Recall

☐ Good ☒ Poor

↳ Patient describes recent news event

☐ Yes ☒ Partially ☐ No

Affect

☒ **Normal**

☐ **Abnormal**

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

☒ **< 3**

☐ **3 or more**

Speech

☒ **Normal**

☐ Apraxia

☐ Slurred

☐ Aphasic

Finger to Nose

☒ **Normal**

☐ Abnormal

Heel (Shin) to Toe

☐ Normal

☐ Abnormal

Thumb to Finger Tips

☒ **Normal**

☐ Abnormal

Sitting to Standing

☐ Normal

☐ Needs Assistance

☒ **Unable**

comments

non-ambulatory

Facial / Extremity Movement

☐ Motor Tic

☐ Vocal Tic

☐ Benign (Essential Tremor)

☐ Intention Tremor

☐ Non-Intention (Pill rolling) Tremor

☐ Rigidity

☐ Spasticity

☐ Chorea Movement

☐ Cog wheeling

☒ **Normal**

Gait

☐ Normal

☐ Limp

☐ Wide based

☐ Abductor lurch

☐ Paretic

☐ Shuffling

☐ Ataxic

☒ **Other (Findings may also apply to Musculoskeletal diagnoses)**

comments

non-ambulatory

Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others)

☒ **Yes**

☐ No

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> BPH |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> ESRD |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Nephritis or Nephrosis |
| <input checked="" type="checkbox"/> Urinary Incontinence | <input checked="" type="checkbox"/> Other |

Urinary Incontinence

Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> History | <input type="checkbox"/> Symptoms | <input checked="" type="checkbox"/> Physical Findings |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Test results | <input type="checkbox"/> Image studies |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> DME | <input type="checkbox"/> Other |

comments

wears briefs daily

Related to stress

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Describe

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Daily | <input type="checkbox"/> Few times a week | <input type="checkbox"/> Less than once a week |
|--|---|--|

Other

Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> History | <input type="checkbox"/> Symptoms | <input type="checkbox"/> Physical Findings |
| <input checked="" type="checkbox"/> Medications | <input type="checkbox"/> Test results | <input type="checkbox"/> Image studies |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> DME | <input type="checkbox"/> Other |

Other

comments

Hypokalemia

History of frequency

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

History of Nocturia

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

History of Hesitancy

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you have trouble urinating?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you ever have blood in your urine?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

Do you have trouble holding your urine?

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

Do you trouble getting to the bathroom on time?

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

Do you ever have pain or burning during urination?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you ever wear pads or diapers?

☒ Yes ☐ No

Do you have a vaginal discharge?

☐ Yes ☒ No

Do you have vaginal bleeding?

☐ Yes ☒ No

Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)

☒ Yes ☐ No

↳ Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture (other than Hip) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Onychomycosis | <input checked="" type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pyogenic Arthritis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Spinal Stenosis | <input checked="" type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Tinea Pedis | <input type="checkbox"/> Other |

Osteoarthritis

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☒ Symptoms ☐ Physical Findings ☐ Image studies
☐ Other

↳ Which joints

comments

knees reports she needs TKR, previously had right THR

Systemic Lupus Erythematosus

↳ Describe

☒ Active ☐ History of ☐ Rule out

↳ Supported by

☐ Labs ☒ Medications ☐ History
☐ other

History / Finding of non- extremity Fracture

☐ Yes ☒ No

History / Finding of Hip Fracture / Dislocation

☐ Yes ☒ No

History / Finding of Vertebral Fracture

☐ Yes ☒ No

Do you have any swelling of your joints?

☒ Yes ☐ No

Do you experience stiffness in the morning or during the day?

☒ Yes ☐ No

Do you have pain in your joints?

☒ Yes ☐ No

Do you have a problem straightening any joints?

☐ Yes

☒ No

Does pain and or swelling in your joints limit your activities?

☒ Yes

☐ No

Have you broken bones(fractures) in any parts of your body?

☐ Yes

☒ No

Do you have constant pain in your bones?

☒ Yes

☐ No

Have you had an amputation?

☐ Yes

☒ No

Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)

☐ Yes

☒ No

Endocrine Problems

☐ Yes

☒ No

Have you lost weight in the past 6 months?

☐ None

☒ 5lbs

☐ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight
(calculated by assessor)

Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)

☒ Yes

☐ No

↳ Diagnoses

☐ AIDS

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other

☒ **Anemia**
☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☐ Vitamin D Deficiency

Anemia

↳ Describe

☒ **Active**
☐ History of

☐ Rule out

↳ Supported by

☐ Lab tests

☐ Symptoms

☐ History of blood transfusion

☒ **Other**

Other

↳ Describe

comments

Medication

↳ Etiology

☐ Iron deficiency

☐ Pernicious

☐ Kidney disease

- ☐ Hemolysis
- ☐ Blood loss
- ☐ Other
- ☐ Aplastic
- ☒ Chronic Disease
- ☐ Chemotherapy
- ☐ Folate Deficiency

↳ If yes, Patient on

- ☐ Iron
- ☐ Blood Transfusions
- ☐ B 12
- ☐ Other
- ☒ Folic Acid

Easy bruising or abnormal bleeding

- ☐ Yes
- ☒ No

Long term anticoagulation use

- ☒ Yes
- ☐ No

↳ Describe

- ☐ Aspirin
- ☐ Coumadin
- ☐ Thrombin Inhibitors (Pradaxa)
- ☐ Plavix
- ☒ Factor Xa Inhibitors (Xarelto, Eliquis)
- ☐ Other

Cancer

Diagnosis of Cancer	Yes	No
---------------------	-----	----

Pain

Does the patient experience pain?

- ☒ Yes
- ☐ No

Is the Pain Acute?

- ☐ Yes
- ☒ No

Is the Pain Chronic?

- ☒ Yes
- ☐ No

↳ Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

↳ Where

knees, LBP

↳ Do you take Methadone

- ☐ Yes
- ☒ No

↳ What drug/s do you take for it

Vicodin and Fiorcet

↳ How bad is your pain on a scale of one to ten with one being very mild and ten being severe

8

Is the Patient Undergoing Pain Management Planning?

- ☒ Yes
- ☐ No

↳ Is the Patient Responding to the Pain Management Plan?

- ☒ Yes
- ☐ No

Was the patient advised regarding the potential for dependence?

☒ **Yes** ☐ **No**

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ **No**

Withdrawal?

☐ Yes ☒ **No**

Increased usage over a longer period that intended?

☐ Yes ☒ **No**

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ **No**

Excess time spent in activities to obtain the substance?

☐ Yes ☒ **No**

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ **No**

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ **No**

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				8

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	2 (Inch)	228 (lbs)	41.7

- ☐ Obesity (BMI 30 – 34.9)
 ☐ Moderate Obesity (BMI 35 – 39.9)
 ☒ **Morbid Obesity (BMI = or > 40)**
- ☐ Malnutrition (BMI < 18.5)

Exam Review

Constitutional

General appearance:	Normal	Abnormal
---------------------	--------	----------

Head and Face

Examination of head and face:	Normal	Abnormal
Palpation of the face and sinuses:	Normal	Abnormal

Comment: Telehealth encounter; limited exam

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Inspection of lips, teeth and gums:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Examination of oropharynx:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Neck

Examination of neck:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Examination of thyroid:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Palpation of chest:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Auscultation of lungs:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Cardiovascular

Palpation of heart:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Auscultation of heart:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Carotid Arteries:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Abdominal Aorta:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Pedal Pulses:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Examination of Arterial Pulses:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Examination of Edema / Varicosities:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: non-ambulatory		
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Assessment of range of motion:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		
Assessment of stability:	Normal	Abnormal
Comment: non-ambulatory; Telehealth encounter; limited exam		
Assessment of muscle strength/tone:	Normal	Abnormal
Comment: Telehealth encounter; limited exam		

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
---	--------	----------

Comment: Telehealth encounter; limited exam

Palpation of skin and subcutaneous tissue:	Normal	Abnormal
--	--------	----------

Comment: Telehealth encounter; limited exam

Neurologic

Indicate specific cranial nerve tested

Telehealth encounter; limited exam - 1, 4, 6, 7 intact

Indicate cranial nerve deficits found

Telehealth encounter; limited exam

Romberg Test	Normal	Abnormal
--------------	--------	----------

Comment: Telehealth encounter; limited exam

Examination of reflexes:	Normal	Abnormal
--------------------------	--------	----------

Comment: Telehealth encounter; limited exam

Examination of sensation:	Normal	Abnormal
---------------------------	--------	----------

Comment: Telehealth encounter; limited exam

Coordination:	Normal	Abnormal
---------------	--------	----------

Comment: Telehealth encounter; limited exam

Diabetes

Foot Exam:	Normal	Abnormal
------------	--------	----------

Comment: Telehealth encounter; limited exam

Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Mood and affect:	Normal	Abnormal

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_	Select	Select			Select				

RETINAL_EXAM									
HBA1C	Select	Select			Select				
MICROALBUMIN	Select	Select			Select				
FOBT	Yes	Select			Select				
DEXA	N/A	Select			Select				
PAD	Select	Select			Select				
LDL	No	Select		LDL	Select				

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.¹⁻³ For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test.

Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version : 2

Person's Answers: Leader, Season, Table

Word Recall :	3 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 Points	Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored.
Total Score :	5 Points	Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further evaluation of cognitive status.

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

- ☒ None
 ☐ Once
 ☐ Twice
 ☐ Three times
 ☐ More than three times

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?	Yes	No
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

42. Are there things about yourself you wish you could change or improve?

"I would like to walk again"

43. Is there anything that you could do to improve your quality of life?

"Exercise more"

44. Have you ever physically or felt emotionally abused by someone

☐ Yes

☒ **No**

45. Feeling like harming others or yourself

☐ Yes

☒ **No**

46. Are you afraid of anyone or is anyone hurting you?

☐ Yes

☒ **No**

Patient Summary

Assessors Comments :

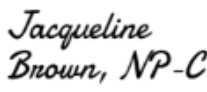

Telehealth visit: Therefore, some areas are left blank due to limited assessment.
Verification of patient: Name and DOB.

HRA completed on Ms. Kimberly Henry who was pleasant and cooperative throughout the entire appointment. She was able to complete her assessment on her own without any assistance or difficulty. Fairly good historian. She was dressed appropriately without any signs of distressed. Her daughter is her primary caretaker whom she lives with. Ms. Henry reports she has been non-ambulatory for 1 year since having COVID in July 2020 complicated by SLE. Multiple hospital admissions. She requires 24/7 care and assistance to complete her ADLs. She would attempt PT/OT while at a SNF but, reports no noted improvement during her stay there. She is eager to ambulate again. May benefit from in-home PT and home health services to assist daughter with the care of patient. Ms. Neekya Craig, patient's daughter was not present during the assessment. It's important to

note, Ms. Henry reported she is no longer being treated for hypertension and hyperlipidemia and associated medications were discontinued by PCM. She is now taking Midodrine for hypotension. She also denies CKD and osteoporosis and denies current prescriptions to support the diagnoses. No lab values available to review for CKD. Upon completion of the assessment, Ms. Henry had no additional questions and/or concerns.

Member Acknowledgment

I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and concerns regarding medical care and treatment or, in the event of an emergency, call 911

Member informed of acknowledgment	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2021-06-05T00:36
Time exam finished	2021-06-05T13:25
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	  Digitally signed by Jacqueline Brown, NP 2021-07-27, 21:35
Addendum	

Disclosure Statement

Your health plan, has contracted with Focus Care to conduct a health exam on all of its Medicare members, including you. The health exam includes questions to help your health plan learn more about your current health. The exam may also find things that could effect your health. The results of the exam will help your health plan and your doctor keep you as healthy as possible.

Personal health information, or PHI, is information in your medical record that identifies the record as your record. PHI includes things like your date of birth, age, address, telephone number, and your medical history.

Most of the time, Focus Care will not release your personal information without your permission. Measures are in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally. You may request more information about how your personal information is protected.

There are times when Focus Care is allowed to release your personal information without your permission. For example, your medical information may be given to

other health care providers who take care of you. The results of this exam will be sent to your health plan and to your doctor.

Focus Care may release your personal health information to a 'business associate'. A 'business associate' is another agency that Focus Care uses to do things, such as billing. We require our 'business associates' to have security measures in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally.

Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.

Focus Care will obtain your permission to use or release your personal health information for any other reason.

Do you have any questions about this information? Would you like to receive this information in a different language?

Your agreement to have this medical exam means you have given your permission to Focus Care to release the results of your medical exam to your health plan and to your doctor. Do you agree?